**STATE OF CONNECTICUT**
**OFFICE OF THE HEALTHCARE ADVOCATE**
**STATE INNOVATION MODEL PROGRAM MANAGEMENT OFFICE**

# REQUEST FOR APPLICATIONS (RFA) FOR PREVENTION SERVICE INITIATIVE – FOR HEALTHCARE ORGANIZATIONS

## SECOND Addendum

## RELEASE DATE – 02-06-2018

The SIM PMO's official responses to questions submitted as of 4pm, February 6, 2018 are as follows:

1. **Question: The Prevention Service Initiative states:**

*Priority Applicants:*

Applicants who are also participating in the first wave of the Medicaid PCMH+ and the Community & Clinical Integration Programs will be given priority in this solicitation. Please note that participation in the Prevention Service Initiative is a new requirement of the PCMH+ program.

**But the PCMH+ Wave 2 RFP states:**

PCMH+ PEs will be required to enter into a written agreement with at least one community-based organization that has been selected to be part of the Prevention Service Initiative. PEs must meet this requirement if they have at least 500 attributed members in one of the three demonstration regions: Bridgeport, New Haven or Middletown. Written agreements should include at least one community based intervention targeting members of the PE's attributed population with one of the target conditions and associated social determinants of health. It is requested that PEs cooperate with the technical assistance process offered as part of the initiative to support successful partnerships. The technical assistance will emphasize demonstrated impact of the prevention services on quality measures that are part of shared savings arrangements.

**Does this mean that the PCMH+ Wave 2 applicants will be required to reimburse the community-based organization for these prevention services as a requirement? That point was not mentioned in the PCMH+ RFP materials.**

Response: The goal of the Prevention Service Initiative is to assist healthcare organizations and community-based organizations in establishing new financial contractual agreements, in which the healthcare organization reimburses the community-based organization for prevention services. The CBOs will be expected to provide an evidence-based service that also attempts to address accompanying social determinant risks. The initiative is based on the assumption that the health system will only refer patients that are attributed under a shared savings arrangement and for whom they are having difficulty achieving positive outcomes. It further assumes that by contracting with the CBO, the healthcare organization will be able to achieve better outcomes, generate savings and, in the case of MSSP, achieve better scores on measures of A1C control. Accordingly, the return on investment should offset the healthcare organizations share in reimbursing the service.

Note, the Prevention Service Initiative is not setting minimum requirements for the scale of the financial arrangement, nor the amount of attributed lives that must be served under the initiative. The scale of the financial agreement will be negotiated between the healthcare organization and the community-based organization at mutually agreeable terms. Additionally, the SIM PMO intends to make available approximately $30,000 per CBO contract to offset the healthcare organization's initial investment. The healthcare organization is asked to contribute 20% of the cost of the agreement for the first six months of the financial contract, and 40% for the subsequent six months. This is intended to establish commitment and a pathway to sustainability for the arrangements while the return on investment is assessed.

2. **Question: In the Prevention Service Initiative, the reimbursement of the community-based organizations is to be paid by the State at 80% for the first 6 months, and 60% for the next 6 months. Does this mean that the Participating Entity would be able to use the grant funds to reimburse the community based organizations for the remainder of the fees? The healthcare organization may not have additional funds for the reimbursement of these services in the absence of grant funding.**

   Response: The healthcare organization is asked to contribute 20% of the cost of the agreement for the first six months of the financial contract, and 40% for the subsequent six months. SIM grant funds may not be used to cover the healthcare organization's contribution.

   The table below illustrates what the healthcare organization might hypothetically pay the CBO over the course of 12 months if it were to take advantage of the full State match. The amount is approximately $12,900. However, there are no minimum requirements for the amount of the healthcare organization's contribution or the scale of the contract. Therefore, the amount the healthcare organization's contribution may vary and may be less than the hypothetical amount. The amount may also be higher, if the healthcare organization chooses to purchase services in excess of the $43,000 combined total in the table below.

   We are interested to hear additional comments or input regarding this. Please submit any further comments to faina.dookh@ct.gov.

   **Table: Hypothetical Healthcare Organization Contribution**

| | First 6 months | Next 6 months | |
|---|---|---|---|
| **CBO Contract** | | | |
| **Total Contract** | $ 21,500 | $ 21,500 | $ 43,000 |
| **State Percentage** | 80% | 60% | |
| **Award per AN/FQHC** | $ 17,200 | $ 12,900 | $ 30,100 |
| **AN/FQHC contribution** | $ 4,300 | $ 8,600 | **$ 12,900** |
| **Operational Investments** | | | |
| **Award per AN/FQHC** | $ 70,000 | $ - | $ 70,000 |

3. **Question: On page 6, it is stated that selected healthcare organizations will receive free technical assistance from an experienced vendor. Has this vendor been selected yet? If so, what organization is it?**

   Response: The selected vendor is Health Management Associates, Inc. or HMA.

4. **Question: The RFA states on page 8 that awards will support successful applicants in three categories. However, it seems that only two categories (Financial Contract with CBO and Operational Investments) are subsequently mentioned. Is there a third category of awards?**

Response: There are only two categories. The mention of three categories was an error.

5. **Question: On page 11, we're asked to answer the "number of practices" we have. Is this question meant for FQHCs?**

   Response: You can respond with the number of sites the FQHC has. If there is only one site, you can state this as a response to the question.

6. **Question: The RFA asks us, on pages 11 and 12, to make estimates of the numbers of "attributable lives" we plan to serve. If we are selected and the proposed technical assistance later provides us with more accurate estimates of those numbers, are we able to revise those numbers then?**

   Response: Providing estimates for this question is sufficient. This number can be later revised.

7. **Question: On page 13, we're asked to provide a Project Plan in narrative form. Are we able to provide this information in chart/table form?**

   Response: Yes, the project plan can be provided in chart or table form.

8. **Question: It seems that two attachments (Consulting Agreement Affidavit [page 18 of RFA] and Procurement and Contractual Agreements Signatory Acceptance [page 21 of RFA]) are required with the application. Our Consulting Agreement Affidavit is uploaded to Biznet. Do we still need to provide a copy of this document with our application?**

   Response: Yes, please provide it with your application.